Greer Pediatric Dental Care
Dr. Mary Okuley

3115 F Brushy Creek Road
Greer , SC 29650
864-879-7977 | gpdcare.com

Welcome!

We are excited to have your child as a patient and we look forward to providing you with everything you need to make your visit to the dentist a positive experience for your family.

As a pediatric specialty practice, we care for the dental needs of children beginning with the eruption of their first tooth and continue to foster a relationship until young adulthood. We also care for those patients with special needs, regardless of age. Specialized care for children includes understanding not only your child's need for dental health, but also how a positive and caring environment can address all comfort needs. We strive to achieve optimum oral health through prevention and education first, and intervention, second. We want to make every experience a positive one so that a lifetime of good oral health may be obtained. Our practice philosophy is to treat and protect every child as if they were our own.

We thank you for choosing our practice for your family's dental healthcare needs. We look forward to taking care of your child/children's needs for many years to come. Should you have any questions or concerns, please feel free to contact us via email or phone.

Kindest Regards,

Dr. Mary Okuley and the Team at Greer Pediatric Dental Care.

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Patient Information

Child's Name ______________________ Name Called By: ______________________

Age ___________ Birthday ______________________ Gender: M☐ F☐

Child's Home Address____
STREET CITY STATE ZIP

Best Contact Phone Number ____

Name of School/Day Care ____

Brothers (Names and Ages) ____

Sisters (Names and Ages) ____

Whom may we thank for referring this patient? ______________________________

Parent Information

Parent/Guardian Name______________________ Relationship to Child______________

Address____
STREET CITY STATE ZIP

Home Phone______________ Cell Phone______________ Work Phone______________

Email Address____

Social Security Number______________ Date of Birth ______________

Employer______________________ Occupation ______________________

Employer's Address____
STREET CITY STATE ZIP

Parent/Guardian Name______________________ Relationship to Child ______________

Address____
STREET CITY STATE ZIP

Home Phone______________ Cell Phone______________ Work Phone______________

Email Address____

Social Security Number _______-________-_______ Date of Birth ______________

Employer______________________ Occupation ______________________

Employer's Address____
STREET CITY STATE ZIP

Emergency Contact/Friend not living with you______________________________

Emergency Home Phone#______________________ Emergency Work Number______________

Insurance Information

Insured's Name_________________________________ Relationship to Patient___________________

Insured's Employer ______________________________ Insured's Date of Birth ___________________

Name of Insurance Company _______________________ Group Number_______________________

Insurance Company Address ____
STREET CITY STATE ZIP

I have received the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental plan benefit plan, unless Greer Pediatric Dental Care has a contractual agreement with my plan prohibiting all or portions of such charges. To the extent permitted by law, I authorize release of any information relating to claims filed.

Signature of Insured____ Date___________________

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Medical History

Family physician or pediatrician ____

Date of last medical examination ____

Has your child had any of the following? Please indicate with a checkmark:

- ☐ Allergies to Anesthesia
- ☐ Allergies to Medicine/Drugs
- ☐ Allergies to_____________ ______________________
- ☐ Anemia
- ☐ Asthma
- ☐ Autism
- ☐ Bleeding Disorder
- ☐ Childhood Illnesses
- ☐ Contagious Disease
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Hearing Disability
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ HIV virus
- ☐ Kidney/Liver
- ☐ Learning Disability
- ☐ Malignancies
- ☐ Measles
- ☐ Mumps
- ☐ Nervousness
- ☐ Oral Herpes
- ☐ Psychological Problems
- ☐ Rheumatic Fever
- ☐ Scarlett Fever
- ☐ Sinus Problems
- ☐ Speech Disorder
- ☐ Stroke
- ☐ Typhoid Fever
- ☐ Tonsillitis
- ☐ Tuberculosis

Does your child have any health problems that require active care of a physician?
☐ Yes ☐ No

Is your child presently taking any medications?
☐ Yes ☐ No
If yes, please list: ____

Has your child ever been hospitalized?
☐ Yes ☐ No
Reason: ____

Do you consider your child to be progressing normally?
☐ Yes ☐ No
If not, explain:____

Dental History

Has your child complained about any dental problem?
☐ Yes ☐ No

Any injuries or surgeries to mouth, teeth, or head?
☐ Yes ☐ No
If yes, explain:____

When did your child stop taking the bottle or sippy cup? ______________________

Do you assist your child with brushing?
☐ Yes ☐ No How often? ______________

Is dental floss used?

☐Yes ☐No How often? ______________________________

Is your home supplied by well water?

☐Yes ☐No

Please check box if your child has any of the following habits

☐Thumb/Finger Sucking ☐Mouth Breathing ☐Pacifier ☐Nail Biting ☐Grinding
☐Other________________

Date of last dental visit ` ______________________________ With whom __________________________

Explain briefly why you brought your child for dental care:

____

I hereby certify that all information is correct and true. Because the above-named child is a minor, it is necessary that a signed permission is obtained from a parent or legal guardian before any and/or all dental treatment can be commenced. I hereby grant such authorization, and shall accept responsibility for any and all fees incurred for such dental services. I understand that I am responsible for all charges whether or not covered by insurance.

Signature____ Date __________________________

Relationship to Patient ____

Greer Pediatric Dental Care
3115 F Brushy Creek Road
Greer, SC 29650

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED BY **Greer Pediatric Dental Care** AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY**.**

YOUR RIGHTS: When it comes to your health information you have certain rights. This section explains your rights**.**

Upon written request:

- Ask to see or get an electronic or a paper copy of your health record or other information we have about you. We will also provide a summary of your health information if requested. We will charge a reasonable, cost based fee. We will provide this information as soon as possible but no later than 30 working days of the request.
- Ask us to correct your health information you think is incorrect or incomplete. We may say "no" but will tell you why in writing within 60 days.
- You can ask us to communicate with you in a certain way (for example, home or office phone) or to send mail to a different address. We will accommodate all reasonable requests.
- Ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree with your request and may say "no" if it would affect your care.
- If you pay for a service or health care item out of pocket in full and you ask us not to share that information for payment or our operations with your health insurer we will agree unless we are required by law to share that information.
- Ask us for a list or an accounting of the times we have shared your health information for reasons other than treatment, payment, healthcare operations, and when you have asked us to share information. We will provide a list for the past six years for the request. One request per year will be provided free of charge. For additional requests we will charge a reasonable, cost based fee.
- Revoke an authorization to use or disclose PHI at any time except where action has already been taken.

You may also:

- Choose someone to act on your behalf. If you have given someone medical power of attorney or they are your legal guardian, that person can exercise your rights and make choices about your health information. We will ask for proof of this relationship before we take any action.
- Ask for a paper copy of this document even if you have agreed to receive the notice electronically. We will provide that copy promptly.
- File a complaint. If you feel your rights have been violated you may contact the designated Privacy Officer, **Dr. Mary Okuley 3115 Brushy Creek Road Suite F, Greer, SC 29650 864-879-7977(P), (864) 879-7118 (F) dr.mary@GPDcare.com**
- File a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, D.C. 20201, calling 1.877.696.6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.
- We will not retaliate for filing a complaint.

OUR RESPONSIBILITIES: The law requires us to:

- Maintain the privacy and security of your protected health information.
- Notify you promptly if a breach occurs that may compromise the privacy or security of your information.
- Follow the duties and privacy practices described in this notice and give you a copy of it.
- Not to use or share you information other what is described in this notice unless you tell us we can in writing. If you tell us we can and then change your mind, just let us know in writing you have changed your mind.

(OVER)

YOUR CHOICES - For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in situations described below, talk to us.

- In these cases you have both the right and the choice to tell us to: share information with your family, close friends, or others involved in your care and share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases we never share your information unless you give us written permission:
  - Marketing purposes
  - Sale of your information
  - Most sharing of psychotherapy notes
  - In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURE – We typically use or share your health information in the following ways:

Treatment: We can use your health information and share it with other professionals who are treating you. Example: we may share your health information to an outside doctor for referral. We will also provide your health care providers with copies of various reports to assist them in your treatment.

Payment: We can use or share your health information to bill and get payment from health plans or other entities. Example: we give information about you to your health insurance plan so it will pay for your healthcare.

Health Care Operations: We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: we use health information about you to manage your treatment and services.

Other ways we can use or share your health information – We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

- **Help with public health and safety issues:** We can share health information about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medication, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health and safety.
- **Comply with the law**: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see if we are complying with federal privacy law.
- **Respond to organ and tissue donation requests:** We will share health information about you with organ procurement organizations.
- **Work with a medical examiner or funeral director:** We can share health information with a coroner, medical examiner, or funeral director when you die.
- **Address workers' compensation, law enforcement, and other government requests:**
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services
- **Respond to lawsuits and legal actions:** We can share your health information to respond to a court or administrative order, or in response to a subpoena.
- **Research:** We can use or share your information for health research.

CHANGES TO THIS NOTICE - We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website.

Dr. Mary Okuley
Dr.mary@gpdcare.com
864-879-7977

Effective date: 10/26/2020

Greer Pediatric Dental Care

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name & Address: ______________________________________
____
____

I have received a copy of the Notice of Privacy Practices for the above named practice.

______________________________   ______________________
Signature   Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:
  ____
- ❑ Other:____
  ____

Prepared By ___________________________________

Signature ___________________________________

Date ___________________________________

Greer Pediatric Dental Care
Authorization for Release of Information – Compound Release

Name of Patient: ________________________________ Date of Birth: _____________

Greer Pediatric Dental Care is authorized to release PHI about the above named patient in the following manner and/or to selected persons.

CHECK EACH PERSON/ENTITY APPROVED TO RECEIVE INFORMATION.	CHECK TYPE OF INFORMATION THAT CAN BE GIVEN TO PERSON/ENTITY ON THE LEFT IN THE SAME SECTION.
☐ Voice Mail	☐ Appointment Reminders
☐ Other person (s) (provide name and phone number)(Example: Spouse, Parent, Relative, Grandparent, Stepparent) ☐ ________________________________ ☐ ________________________________ ☐ ________________________________	☐ Financial ☐ Treatment
☐ Email communication-Provide email address* ____________________________ *For email communication to occur, accept the disclosure below:	☐ Financial ☐ Treatment ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * ____________________________ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: ____________________________

☐ For **text and email communication** I understand that if information is *not* sent in an encrypted (secure) manner, there is a risk it could be accessed inappropriately. I still elect to receive text and email communication as selected.

- I have the right to revoke this authorization at any time by contacting this office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

Signature of Patient or Personal Representative: ____________________________________ Date: ________

*Description of Personal Representative's Authority (attach necessary documentation)

☐ Revoked by patient or personal representative on ______________________.
DATE

How revoked: ☐ orally (in person or via phone) ☐ in writing (place copy in patient's file)

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APPOINTMENT POLICY

We reserve time for each and every patient. Your child's scheduled appointment is specifically for him/her. Any change in this appointment affects many other patients. If a cancelation is unavoidable, please call the office in advance so that we may give that time to another patient.

I, ______________________________, (Parent/Legal Guardian) understand that if I fail to give a 24- hour advance notice for a regular scheduled appointment or a 48- hour advance notice for a sedation appointment on more than 2 occasions, my child(ren) will be dismissed from Greer Pediatric Dental Care.

Signature: ______________________________

Date: ______________________ Patient's Name: ______________________

PUBLICATIONS, PICTURE, AND INTERNET RELEASE FORM

As you are aware, there are potential dangers associated with the posting of personally identifiable information on a web site. Since global access to the Internet does not allow us to control who may access such information, these dangers have always existed. However, as your child's care provider, we want to celebrate your child and his/her good dental habits and behavior. The law requires that we ask your permission to post information about your child in the public domain.

Please check one of the following:

- ☐ I hereby grant permission for any photos/image and name to be published on the Greer Pediatric Dental Care internet site, media, newsletter, and/or promotional materials.
- ☐ I hereby grant permission for any photos/image (but not name) to be published on the Greer Pediatric Dental Care internet site, media, newsletter, and/or promotional materials.
- ☐ I do not grant permission for my child's photo/image or name to be published by Greer Pediatric Dental Care internet site, media, newsletter, and/or promotional materials.
- ☐ I also acknowledge that Greer Pediatric Dental Care may choose not to use my photo at this time, but may do so at its own discretion at a later date.

This release will supersede any previous releases on file.

Parent/Guardian name: (Please Print) ______________________________

Signature: ______________________________

Patient's name: ______________________ Date: ______________________